OMB Approval: 0930-0169

Expiration Date: 11/30/2003

PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS (PAIMI) PROGRAM

ANNUAL PROGRAM PERFORMANCE REPORT (PPR)

STATE: Virginia

FISCAL YEAR: 2000

Three copies of the Annual Program Performance Report (PPR) should be submitted no later than January 1 to the attention of :

Protection and Advocacy Section - Room 15C - 21
Center for Mental Health Services
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-3667/FAX (301) 594-0091

Please use the attached glossary and instructions to complete the form. All questions should be addressed to the Protection and Advocacy Section at the above address and telephone number.

PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS (PAIMI) PROGRAM

ANNUAL PROGRAM PERFORMANCE REPORT (PPR)

FISCAL YEAR: **2000**

STATE: **Virginia**

NAME OF P&A SYSTEM: **Department for Rights of Virginians with Disabilities**

NAME OF PAIMI PROGRAM (If Different): _____

REPORT PREPARED BY: **Heidi Lawyer**

TELEPHONE NUMBER: **804-225-2015**

E-MAIL ADDRESS: **lawyerhl@drvd.state.va.us**

DATE SUBMITTED: **12/1/00**

SECTION I. PAIMI PROGRAM GENERAL INFORMATION

A. DESCRIPTION OF Protection and Advocacy (P&A) System PAIMI Program:

1. Name of PAIMI Coordinator: Clyde W. Mathews, Jr., Esq.
2. Name and Address of designated P&A System**:**
   a. Main office: **____Department for Rights of Virginians with Disabilties__**
   ____202 N. Ninth Street, 9th Floor
   ____Richmond, VA 232319

3. Satellite office(s) (if applicable): **_114 McTanly Place**
   Staunton, VA 24401____

B. GOVERNING BOARD, ADVISORY COUNCIL AND PAIMI STAFF (on 9/30)

1. Does the P&A have a multi-member governing board? Yes___ No__**X**_
   (If Yes, complete the governing board columns of the Tables in B 3.)
2. Is the Chair of the PAIMI Advisory Council a member? Yes___ No___
   (If No, please explain.)
3. Provide the number for the Advisory Council and the Governing Board as requested in the table below. Indicate the **one primary identification** of **each** member as of 9/30. **Count each member only once**.

	Advisory Council	**Governing Board**
Total Number of Members on 9/30 of Fiscal Year	**14**	
Term of Appointment (Number of years)	**4 years**	
Number of Terms a Member Can Serve	**1 (consecutively)**	
Frequency of Meetings	**Quarterly**	
Number of Meetings Held in the Fiscal Year	**4**	
% (Average) of Members Present at Meetings	**74%**	
Recipients/Former Recipients (R/FR) of Mental Health Services	**6**	
Family Members of R/FR of Mental Health Services	**3**	
Mental Health Professionals	**1**	
Mental Health Service Providers	**1**	
Attorneys	**0**	
Individuals From the Public Knowledgeable About Mental Illness	**3**	
Other Persons Who Broadly Represent or Are Knowledgeable About the Needs of Mentally Ill Individuals		

TOTAL	**14**	

SECTION 1. B (contd.)

4. Does the P&A program utilize volunteers? __No___

If so, describe how volunteers are used to supplement the activities of the P&A and include activities such as monitoring, fund raising, training, etc.

5. Are PAIMI services and activities to individuals with mental illness and their families supported by funding other than that provided by Federal dollars or P&A program income?

Yes / X / No / /

If yes, provide a brief, succinct description of any services and activities supported by non-Federal funding or P&A program income. Please, include in this description, any State funded advocacy services provided to the individuals served.

Virginians with Disabilities Act Funding is used to address discrimination against people with disabilities including people with mental illness. Primary activities under this program were employment discrimination and program, facility, service and public accommodation accessibility under ADA Titles, II and III. Funding from this program in FY 2000 was $208,050.

C. PAIMI PROGRAM STAFF:

1. Provide the total of staff paid either partially or totally with PAIMI funds or from P&A program income 12
   a. Of the above total, how many staff are attorneys? 2
   b. Of the above total, how many are non-attorney case workers? 2

Ethnicity	**Staff**	**Advisory Council**	**Governing Board**
Hispanic or Latino	0	0	N/A
Not Hispanic or Latino	0	0	

Race	**Staff**	**Advisory Council**	**Governing Board**
American Indian or Alaska Native	0	1	N/A
Asian	0	0	
Black or African American	0	2	
Native Hawaiian or Other Pacific Islander	0	0	
White	12	11	
Gender			
Male	3	9	N/A

Female	9	5	
Total	12	14	

SECTION II. PAIMI PROGRAM PRIORITIES and DESIRED OUTCOMES

Below, list PAIMI program priorities and objectives that were the targets of this fiscal year's program activities. For each priority, provide an example of an individual or systemic case and, if applicable, a legislative activity. **Please include examples of PAIMI Program participation in State mental health planning activities**. Remember case examples should illustrate the impact and/or disposition of PAIMI program efforts. See **Glossary** for definitions.

Provide the following information and complete this form for **each priority** identified for the fiscal year.

1. Priority # P/__/

2. For each indicator of success, provide the following information:
   1. (1.1) Indicator #
   b. Indicator was: /__/Met /__/Partially Met/Continuing /__/Not Met
   If "Not Met" was checked, explain:

   If "Met" was checked, summarize details, including one or two cases that exemplify the success; for fully met objectives, the example case(s) should be successfully closed

Please select case examples that best reflect the activities related to this priority. Describe the outcome of an activity and write the case example as though you were telling a story. Include the following information in your case narrative(s): what happened (the facts about the situation); why the P&A program became involved; how the P&A program made a difference; and, what the resulted from this P&A activity? For example, "as a result of P&A intervention, this client lives independently in the community, goes to work every day . . ."

Priority 1

To protect the rights of individuals residing in DMHMRSAS-operated facilities to be free from abuse and neglect or a pattern of abuse or neglect which results in severe injury. The FY 2000 focus will be on representing the interests of individuals who are at imminent risk or who have been subjected to (1) physical, sexual, or psychological abuse, including the use of seclusion and restraints and/or lack of access to medication; or (2) physical neglect, including lack of access to treatment.

Indicator 1: To protect the legal rights of and represent the interests of individuals who are subjected to abuse or neglect as defined in the Priority.

1.1. To provide information and referral services and/or technical assistance services to all individuals who contact DRVD regarding an issue related to abuse and neglect.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

Information and referral services and technical assistance services are provided to all callers.

1.2. To provide case level advocacy services to persons who meet the established case selection criteria of whom at least 20% shall be members of minority populations.

1.3. To provide legal representation services to persons who meet the case selection and litigation selection criteria of whom at least 25% shall be minorities.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

Case level advocacy and representation services were provided to individuals whose issues fell with the priority. The percentage of minorities served by advocacy and/or legal representation was 21%, fairly consistent with the projected levels for representation of minorities. Case examples are listed below.

1.4. To conduct investigations of deaths and/or severe abuse or neglect at a mental health facility operated by DMHMRSAS. Where there are findings of abuse and neglect, to pursue appropriate systemic/legal remedies.

Indicator was: /X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

Abuse, neglect, and death investigations were conducted at DMHMRSAS-operated mental health facilities. Case examples are below and death investigation activity is reported under Section IV of this report.

1.5. To undertake a systemic on-site review at one or more targeted DMHMRSAS facilities of the use of seclusion and restraint.

Indicator was: / /Met / X /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

The PAIMI team conducted a systemic review of the use of seclusion and restraint at Western State Hospital. The staff reviewed seclusion and restraint data and conducted a site visit to the facility in mid-April. With the assistance of WSH staff, all residents who were secluded or restrained during the previous quarter (January to March 2000) were identified, and DRVD interviewed all who were still present at the facility. Relevant records were reviewed and questionnaires for each incidence of seclusion/restraint were completed. The PAIMI staff compiled the information in a draft report that examines the data in light of written policies regarding seclusion and restraint, and includes a three year trend analysis of seclusion and restraint use and a policy analysis of HCFA and JCAHO regulations. The report is undergoing final review of the policy analysis in light of the Children's Health Act of 2000 enacted on October 17, 2000, which establishes nationwide minimal standards for use of seclusion and restraint. The completed report will be shared with the Commissioner of DMHMRSAS, the facility director, and others as appropriate.

1.6. To support the work of the Inspector General by participating collaboratively in IG

on-site monitoring and reviews of conditions at DMHMRSAS facilities.

Indicator was: / /Met / /Partially Met/Continuing / X/Not Met
If "Not Met" was checked, explain:

PAIMI staff had been asked to accompany the IG on several facility visits during the last fiscal year but little collaborative activity has taken place. The Inspector General was asked to participate in the review of seclusion/restraint usage at WSH but her schedule did not permit participation in this effort. The PAIMI Staff attorney is working with the IG on a case out of Northern Virginia Mental Health Institute. The IG convened a peer review panel to discuss the case and indicated that she would share her findings with DRVD when they were complete. This report has not yet been provided.

This objective has not been carried forward. PAIMI staff will continue to explore appropriate collaborative activities, including as appropriate, joint site visits, in support of other program priorities. PAIMI staff will also routinely report to the IG any systemic issues regarding patient care identified during regular outreach and monitoring activities. Potential barriers to collaboration include sharing of confidential patient and client information, and the availability of the IG to work collaboratively with DRVD on systemic issues due to scheduling and workload issues.

Indicator 2: To advocate for necessary changes to the internal DMHMRSAS investigations procedures to ensure that policy, procedure, and practice are consistent with accepted standards for competent investigations.

2.1. To advise DMHMRSAS on identified deficiencies in policy and/or the implementation of policy.

Indicator was: / /Met / X /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

Status of Objective. Establishment of a formal liaison with the recently established DMHMRSAS Office of Consumer Affairs was initially delayed due to organizational delays within DMHMRSAS regarding functions and responsibilities of that office. Subsequently, the Commissioner of DMHMRSAS advised that no formal collaboration would be supported. Advocates continue to request and review investigative reports in individual cases whenever an investigation has been conducted and the client authorizes access to the report. It has been found that the reports conducted at one facility are generally limited in scope and look at the specifics of the complaint but do not address standards of care, medication management, and treatment planning and how those might have impacted the circumstances surrounding the incident.

DMHMRSAS issued a new Departmental Instruction #201, *Reporting and Investigating Abuse and Neglect*, effective April 17, 2000. Only employees who have successfully completed the "Investigations Training" can be assigned to investigate facility abuse and/or neglect. The new MOU between DRVD and DMHMRSAS is now in effect and provides for monitored referral of complaints to DMHMRSAS, with outcome reporting to DRVD. As of July 1, legislation went into effect requiring notification to DRVD of all deaths and critical incidents in DMHMRSAS facilities. Follow-up pursuant to the MOU and statutory notification will increase access to and review of

investigative reports. Joint DRVD/DMHMRSAS statewide training on the provisions of the new MOU was conducted in June 2000.

This objective has been modified and carried forward. DRVD will continue to request selected investigative reports based upon review of critical incidents reported in accordance with the MOU and in individual cases. DRVD will identify deficiencies, if any, in reports, and recommend, as appropriate, revisions to investigative policies and procedures.

2.2. To pursue administrative or legal action as appropriate regarding deficiencies in DMHMRSAS investigation practices.

Indicator was: / /Met / /Partially Met/Continuing / X /Not Met
If "Not Met" was checked, explain:

See Indicator 2.1 above regarding implementation of the first component of this indicator. This objective has been carried forward and will be pursued as appropriate if serious deficiencies are found and the Department is unresponsive to DRVD's recommendations.

Indicator 3: To increase the awareness of facility residents and their families of DRVD services and legal rights through outreach, technical assistance, and training activities.

3.1. To provide information and referral services and/or technical assistance services to all individuals who contact DRVD who are PAIMI eligible but who do not meet the agency's priorities and/or case selection criteria.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

All callers to the agency are provided information, referral and/or technical assistance services, as appropriate.

3.2. To increase access to and utilization of DRVD services by consumers in DMHMRSAS mental health facilities by meeting with consumers/families, facility staff, and/or human rights staff at NVMHI, Western, and Central State Hospitals.

3.3. To inform consumers about DRVD's representation priorities and to educate clients through distribution of information, regarding consent to treatment, including the following areas: medication, seclusion and restraint, general rights, and discharge planning.

Indicators 3.2 and 3.3 were / /Met / X /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

Status of Objectives 3.1 – 3.3. The specific objective was for 4 visits monthly to the targeted institution, or a total of 48 for the year. This was exceeded at Western State with a total of 50 visits. At Central State, 37 visits were made during the year However, due to split assignment, this advocate also had 19 visits to Eastern State for a total of 56 facility visits. There were 28 visits to Northern Virginia Mental Health Institute this year. The lesser number of visits was in part due to a staff vacancy for part of the year. Visits were also made on an as needed basis to other

facilities, including Southwest Virginia Mental Health Institute, Catawba, Piedmont Geriatric Facility, and Hyram Davis. While visiting facilities, the advocates and attorneys routinely meet with residents to discuss the PAIMI priorities and various PAIMI issues. They distribute brochures throughout the facilities, visited the wards to ensure that PAIMI posters are in place, and provide additional posters as needed. They also attend Local Human Rights Committee (LHRC) meetings on a regular basis. They have ongoing contact with the facility directors and internal human rights advocates regarding mutual clients, facility, program and other issues.

3.4. To present at least 4 trainings/ per PAIMI advocate in facilities, clubhouses, and/or consumer run programs on the rights issues listed in Objective 3.3.

Indicator was: / /Met / X /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

DRVD provided training on mental health rights, abuse and neglect, through LEAP ("Leadership, Empowerment, Advocacy Program"), a consumer based advocacy program in southwestern Virginia. The first training was conducted in February 2000 at the Highlands Clubhouse in Abingdon, Virginia, and involved 30 consumers using a "train-the-trainer" model. It is anticipated that we will provide additional training as requested, approximately twice a year.

The advocate at WSH delivered four trainings which included a Discharge Planning training at WSH's Stribling Psychiatric Treatment Mall; a Seclusion and Restraint Training at the Treatment Mall, a Client Rights and Issues Training for the WSH Citizen Council, and a training on General Rights to the Southwestern Virginia Consumer and Family Involvement Project at the Highlands Clubhouse in Abingdon. The new PAIMI staff attorney conducted one training, presenting to approximately 5 clients and staff at Psychiatric Resources, Inc. in Alexandria, Virginia. This organization has indicated that it would like her to return every 6 months to talk with consumers about DRVD services.

The advocate covering Central State Hospital did not conduct any formal training this fiscal year. However, outreach at CSH was successful as the advocate is well-recognized and continues to generate cases within the priority areas. She reported that DRVD training materials are already included in the groups conducted by CSH staff, and that the concerns of consumers in the community are more focused on rehabilitation services, employment, and housing issues. According to the advocate, formal training was more useful when patients were not involved in active treatment for the majority of the day. Therefore the emphasis was on maintaining general visibility and accessibility rather than conducting formal training sessions. Training objectives have been carried forward to FY 2001.

CASE EXAMPLES AND SYSTEMIC ACTIVITY FOR PRIORITY 1

Example 1. ST, a 20 year old, female contacted DRVD on December 17, 1999 to report that the state hospital was failing to provide her with appropriate mental health treatment. A PAIMI advocate met with ST at the hospital to discuss her complaint and review her medical records. ST reported that she needed medication to decrease her paranoia and agitation and that her physician had recently discontinued this medication for her. The PAIMI advocate met with ST and her physician regarding ST's request to have continued access to medication for paranoia and agitation. ST's physician explained to ST that other

lesser restrictive methods of addressing her paranoia and agitation needed to be utilized before resorting to the use of medication such as talking with staff and using quiet time in her room to calm down. He stated that if these lesser restrictive alternatives did not work for her that he would order medication for her at that time. ST's physician also explained that he had recently increased ST's antipsychotic medication to alleviate her increase in paranoia, and that she had agreed that this had helped. ST was very satisfied with the outcome of this meeting and thanked DRVD for assistance in meeting with her physician and getting her issue resolved.

Example 2. WM was a patient at CSH who was restrained and subjected to an unnecessary body cavity search by staff. An investigation by a PAIMI advocate substantiated that the search had been conducted in a public area, contrary to facility policy, and that the attending physician ordered the search without sufficient factual basis and contrary to facility policy regarding the use of lesser intrusive means. The facility also conducted an internal investigation. The physician's contract to provide services was terminated as a result of this incident. The case has also been assigned to a DRVD Contract Attorney and a lawsuit for damages was filed in August 2000 in the Circuit Court of Dinwiddie County. Legal discover in the case is ongoing.

Example 3. DRVD was contacted by CP, a 26 year old white female with mental illness (Anti-Social Personality Disorder; Borderline Personality Disorder) on January 6, 2000 during a facility visit by a DRVD attorney. CP advised the DRVD staff attorney visiting the state mental health facility on January 6, 2000 of her concerns about the facility's use of restraints in her case. CP had been at the hospital for most of the previous three years. She had been in restraints frequently during her hospitalization due to repeated aggressive outbursts. CP was in restraints (wrist restraints attached to a waist belt or ankle restraints or both) for a total of 31 days 14.5 hours from 11/24/99 to 01/04/2000. That's a total of 758.5 hours out of a 980.5-hour time period (77%). During this time, the orders read "no criteria for release." Issues have been discussed case with CP, the facility director, the facility advocate, CP's parents, and the then-chairperson of the Local Human Rights Committee. This case is ongoing.

Example 4. A PAIMI Staff attorney has two related cases involving two Caucasian female patients at a state mental health facility. LM, 40 years old and AC, 19 years old. These cases were opened as a result of the recently passed legislation providing DRVD with notification of critical incidents in state facilities. In the case of LM, DRVD received a 14-day report of an unfounded incident of unspecified type on 6/26/00. The case was referred to a PAIMI advocate who met with the client and opened a case. At about the same time, DRVD received a second critical incident report indicating an alleged rape at the same facility. The PAIMI advocate met with AC in early August and a case was opened. Both cases were assigned to the PAIMI staff attorney. It was determined that LM and AC were raped within a month of each other in the maximum-security forensic unit at the state hospital. Each rape occurred on the same ward and during the same shift (overnight shift). It was found that the patients are not allowed to shut their doors on this co-ed ward and no staff was stationed in the hallway to protect the patients from unwanted intruders. The female patients at that time had private rooms which were directly across the hallway from the male patients. Both cases are being prosecuted by the local Commonwealth's Attorney's office. The DRVD staff attorney has reviewed the records of both women; interviewed both women; received and reviewed the internal investigation reports; attended the preliminary hearing in LM's case; and viewed the facility surveillance videotape from the time of the rapes. These reports were received as part of the critical incident reporting process. The

staff attorney has worked with/talked to staff at the facility, including the facility director's assistant, the director of security for forensic services, the facility director of risk management, and ward social worker. These two investigations are ongoing.

Systemic Activity

1. Legislation proposed by DRVD through the Governor and passed by the General Assembly, included the following:

   A. **State statutory access to facilities, records, and clients**. This law provides statutory access to DRVD as the state's protection and advocacy entity, to have reasonable, unaccompanied access to facilities and institutions (as defined in 37.1-1 and 37.1-179) and all other facilities and institutions that provide care or treatment to individuals with disabilities. This includes reasonable access to clients, records, and facilities for purposes of investigating allegations of abuse or neglect and conducting other activities necessary to protect the rights of persons with disabilities.

   B. **Notification of all critical incidents and deaths in facilities** operated by the Department of Mental Health, Mental Retardation, and Substance Abuse Services. This law provides DRVD with timely information concerning critical incidents or deaths in facilities operated by DMHMRSAS. DRVD had received, under an informal agreement, general notification of deaths in facilities but received no notice of critical incidents. The information received prior to the passage of this law, provided only a date of death & a facility. It omitted the patient's name, authorized representative and any circumstances of death, thus hindering DRVD's ability to determine probable cause or pursue a timely investigation and correction/resolution of the incident which occurred. Statutory notification ensures that DRVD is provided with sufficient facts regarding the individual in question and the circumstances surrounding the critical incident or death to reasonably determine if abuse or neglect occurred. A critical incident is defined as serious bodily injury or loss of consciousness requiring medical treatment.

   C. **Confidentiality of DRVD client and investigative records**. The passage of this legislation was critical to ensure confidentiality of records, notes, documents, reports, or other information or material collected by DRVD in the course of representing someone who alleges abuse, neglect, or discrimination. DRVD, as the state's protection and advocacy system, provides legal services to its clients in the same manner as a law firm.

2. **Memorandum of Understanding.** In the spring of 1999, DRVD identified the need to revise its agreement with DMHMRSAS regarding access to facilities, residents and records at state facilities. As a result of extensive negotiations, a revised Protection and Advocacy Memorandum of Understanding (MOU) on access was entered on April 10, 2000, between DRVD and DMHMRSAS. Critical elements of the MOU are:

   A. Unaccompanied and unannounced access to all state facilities and residents 24 hours per day, 7 days per week;
   B. Immediate on-site access to client records, with copies of voluminous files provided within 15 days;
   C. A written notification procedure for findings of probable cause by DRVD, with

clarified access to facility records and staff to conduct a full investigation;
D. Notification to DRVD of all critical incidents or deaths within 48 hours;
E. The "monitored referral" of client complaints to the internal DMHMRSAS investigative process, with a mechanism for outcome reporting to DRVD;
F. Access to facilities and residents to conduct outreach and training activities, with DRVD posters and educational materials displayed in all state facilities.

On June 27, 2000, DRVD and DMHMRSAS conducted a joint training of all PAIMI and DD advocates, DMHMRSAS Human Rights Advocates, and other key DMHMRSAS staff to include all facility directors, medical directors and risk managers. All remaining state facility staff will receive training on the MOU within 180 days. The Access MOU has also been posted on the NAPAS website as a "model agreement" for other P&A's.

3. **Critical Incident Monitoring**. As a result of the new legislation discussed in # 1 above and revisions to the Memorandum of Understanding reported in # 2 above, the DRVD Director began receiving notification of deaths and critical incidents in May 2000, although the legislation did not become effective until July 2000. Informal notification of deaths had been occurring previous to that time. Since that time, the DRVD director has reviewed every 48 hour report provided by the facility directors and every 15 day follow-up report provided by the DMHRSAS Commissioner. DRVD has developed a comprehensive database to log in all reports and to track incidents in a variety of different ways (including, but not limited to tracking by facility, by ward, by time of day/shift, by type of injury, etc.) The DRVD Program Operations Coordinator provides summary monthly reports to the DRVD Director as part of the agency's efforts to track and analyze trends in the aggregate and to determine actions which should be taken to remediate ongoing systemic problems. This is accomplished in part through monthly meetings between the DRVD Director and the DMHMRSAS Commissioner. When the Director determines probable cause to suspect abuse or neglect, or if probable cause is unclear, staff are assigned intervention activities from the level of preliminary inquiry to full investigation, depending upon facts of the incident. Receipt of critical incident information has enabled the agency to become more proactive in addressing both individual and systemic problems in the DMHMRSAS system.

4. **Mental Health Planning Council.** A PAIMI advocate serves on the state Mental Health Planning Council (MHPC). The mission of the MHPC is to advocate for a consumer and family-oriented, integrated and community-based system of mental health care of the highest quality. The MHPC reviewed the Federal Block Grant Application which includes the state's comprehensive mental health plan pursuant to P.L. 102-321. A DRVD advocate was selected to chair the advocacy committee of the MHPC and be a member of the executive committee. The MHPC met for a two day retreat and eleven monthly meetings in the last fiscal year. There were also executive committee meetings between council meetings.

In the past year, the MHPC has focused on re-inventing itself to address its responsibilities more fully and to become a meaningful advocacy voice in the Commonwealth. Consumer membership has been greatly expanded. The MHPC has supported funding for the development of a support system for consumer run programs, increased funding for those programs, and training for consumers and families. The Council competed successfully for a grant from CMHS for enhancing

consumer participation in the public mental health system. The funding will become available in FY 2001. Major areas of focus this year have been the development of comments on the proposed human rights regulations, beginning to rewrite the DMHMRSAS 'regulations for licensure of community programs and the state's response to the *Olmstead* decision. The MHPC has successfully advocated for the inclusion of MHPC representatives on major Departmental workgroups.

5. **Investigation Process.** The advocate covering Central State Hospital Met routinely with facility advocates and directors in effort to identify any emerging patterns or concerns. She met with the supervisor for the DMHMRSAS investigation process, on two occasions to discuss concerns over barriers to quality investigations. She invited the supervisor to the HPC to discuss the investigational process and the new Departmental Instruction regarding DMHMRSAS investigations. The MHPC shared concerns about timeliness of the review process and that the work load in reviewing the investigations was too great for one person to manage effectively.

6. Additional relevant legislation which DRVD reviewed and/or monitored/commented on covered such issues as

   - Hiring of staff by community services boards, local departments, behavioral health authorities and agencies licensed by DMHMRSAS pending completion of criminal background checks
   - Licensing of adult care residences
   - Civil Rights Act of 2000 (proposing creation of super-agency)

Priority 2

To protect the rights of individuals residing in hospitals, licensed adult care residences, and nursing homes providing care and treatment for mental illness to be free from abuse and neglect or a pattern of abuse or neglect which results in severe injury. The FY 2000 focus will be on making monitored referrals with follow-up to the primary agencies responsible for investigating reports of imminent risk and/or incidences of abuse and neglect in these facilities. In the event that there is no primary investigative agency, DRVD may, in accordance with case selection criteria, conduct investigations of incidences of physical, psychological, or sexual abuse, and/or physical neglect

Indicator 1: To ensure that allegations of abuse and neglect are properly reported and investigated by primary investigative and licensure agencies.

1.1. To provide information and referral services and/or technical assistance services to all individuals who contact DRVD who have been or are at risk of abuse or neglect.

Indicator was: / X/Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

All callers to the agency receive I&R and/or TA as appropriate.

1.2. To provide monitored referral to responsible licensure and enforcement agencies when a complaint of abuse or neglect is received.

Indicator was: / /Met / X/Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

Referral and follow-up were provided when complaints of abuse or neglect were received for which there was a primary investigative agency. Case examples are below.

1.3. To collaborate with primary licensure and enforcement agencies regarding reports of abuse or neglect

Indicator was: / /Met / /Partially Met/Continuing / X /Not Met
If "Not Met" was checked, explain:

This objective was carried out collaboratively with the DD Program**.** Primary points of contact at each of the licensure agencies were contacted. Statutory authority for each licensure entity was identified and current reports on activities were requested. A list of programs currently licensed as ACRs and nursing homes was obtained. Letters to the key contact persons were sent out; follow-up telephone calls were made, and meetings conducted with the enforcement personnel of each agency. Unfortunately, the enforcement agencies contacted have not been willing to enter into a formal MOU with DRVD regarding monitored referral of complaints, however, individual complaints are being addressed and referred, as appropriate.

1.4. To conduct investigations of abuse or neglect when there is risk of or which results in severe injury or death when there is no primary investigative agency. Where abuse or neglect is found, to pursue appropriate systemic or legal remedies.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

To date, no cases have been identified in which there was no primary licensure or enforcement agency. DRVD will continue to refer cases to appropriate investigative authorities and conduct investigations, if necessary, in accordance with case selection/litigation criteria. This objective has been carried forward to FY 2001.

CASE EXAMPLES AND SYSTEMIC ACTIVITY FOR PRIORITY 2

Example 1. In June 2000, DRVD received a report from a local social services department regarding an allegation of abuse of a resident of an adult care residence (ACR). A PAIMI advocate contacted Adult Protective Services and the Division of Licensure to ensure that an appropriate investigation had been commenced. The Department of Social Services and Long Term Care Ombudsman completed a joint investigation which concluded that the allegation of abuse was founded. An investigative summary was provided to DRVD. The ACR was cited for licensure violations and a corrective Action Plan was approved. DSS Licensure also provided in-service to the ACR staff on the management of aggressive behaviors in clients. The client was placed in a different facility and was satisfied with the outcome of the investigation.

Example 2. DRVD was contacted by the parent of a young man who died while a patient in the psychiatric unit of a community hospital. The parent alleged that his death was the result of negligence on the part of facility staff. She had already filed a complaint with the appropriate licensure agency and contacted private counsel about representation. DRVD assisted by reviewing complaint drafts to other entities (both state and federal) and reviewing the follow-up by these agencies. The licensure agency (DMHMRSAS)

investigation was excellent and provided the framework for litigation.

Example 3. MS, a 45 year old female contacted DRVD to report that she had been subjected to excessive seclusion and restraint at a local hospital. She became a client of DRVD on September 11, 2000. Her case was opened for monitored referral under PAIMI Priority Two.

Before MS contacted DRVD she had already made a complaint to the hospital ward nurse regarding the incident of excessive seclusion and restraint. DRVD informed MS of the appropriate agency who had primary responsibility for investigating incidences of abuse and neglect for local hospitals. She contacted this agency and made a formal complaint regarding the incident at the local hospital. DRVD also informed MS of the organization that accredits the local hospital as well as the department of health professions who licenses nurses and physicians.

DRVD obtained MS's medical records from the local hospital regarding the incident and reviewed the with MS. MS did not agree with the behaviors identified or with the hospital's discharge summary. DRVD asked MS to write a letter to the physician who wrote her discharge summary and identify the areas that she disagreed with and why. MS completed the letter. DRVD sent MS's letter, with an attached cover letter from DRVD, to MS's physician requesting a timely response to her request.

DRVD talked with MS's physician to discuss her disagreement with her discharge summary. MS's physician sent her a response explaining that he would attach her disagreements to the discharge summary but that he could not change the permanent record. MS's complaint of excessive seclusion and restraint is ongoing at this time. The results of the primary agency's investigation have not been finalized as of yet, therefore follow-up has not been completed by DRVD. MS currently lives in the community and has not been hospitalized since this incident occurred.

Systemic Activity

1. **State statutory access to facilities, records, and clients**. This legislation also applies to Priority 2 as it provides statutory access to DRVD to have reasonable, unfettered access to facilities and institutions (as defined in 37.1-1 and 37.1-179) and <u>all other</u> facilities and institutions that provide care or treatment to individuals with disabilities. This includes reasonable access to clients, records, and facilities for purposes of investigating allegations of abuse or neglect and conducting other activities necessary to protect the rights of persons with disabilities.

2. Relevant legislation which DRVD reviewed and/or monitored/commented on covered such issues as

    - Hiring of staff by community services boards, local departments, behavioral health authorities and agencies licensed by DMHMRSAS pending completion of criminal background checks
    - Mental health pre-discharge planning
    - Notice of group homes for persons with mental illness and/or mental retardation
    - Zoning of group homes
    - Licensing of adult care residences

- Institutionalization of children with developmental disabilities: Study
- Civil Rights Act of 2000 (proposing creation of super-agency)
- Study on Medicaid "buy-in" option for people with disabilities

Priority 3

To provide advocacy and legal representation to clients in DMHMRSAS facilities regarding lack of informed consent to treatment by the client or by a properly appointed substitute decisionmaker

Indicator 1. To protect the legal rights of persons who have received treatment in the absence of informed consent or a properly authorized substitute decision-maker.

1.1. To provide information and referral services and/or technical assistance services to all individuals who contact DRVD regarding lack of informed consent or appointment of an authorized representative as defined in the Priority.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

All callers to the agency are provided I&R and/or TA services as appropriate.

1.2. To provide case level advocacy services to persons who meet the established case selection criteria of whom at least 20% shall be members of minority populations.

1.3. To provide legal representation services to persons who meet the case selection and litigation selection criteria of whom at least 25% shall be minorities.

Indicators were: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

Case level advocacy and representation services were provided to individuals whose issues fell with the priority. Twenty nine percent of persons served were minorities. Case examples are listed below.

1.4. To award one or more contracts to a non-profit organization which will work in collaboration with DRVD to provide information and training on the Health Care Decisions Act, including options for substitute decision-making and advanced directives related to mental health needs.

Indicator was: / /Met / /Partially Met/Continuing / X /Not Met
If "Not Met" was checked, explain:

DRVD engaged in initial discussions with a mental health consumer organization regarding the collaborative development of video and supporting materials on surrogate decisionmaking and advance directives. However, the primary contact person for the consumer organization has experienced extensive illness this year and no proposal was submitted to DRVD. In addition, there has been an extensive delay in promulgation of revised DMHMRSAS HR regulations regarding authorized representatives and surrogate decisionmaking. This objective was not carried forward. Training in this area will be provided at the Statewide Mental Health Human Rights Conference in the Spring of 2001.

Indicator 2. To ensure that the human rights regulations being promulgated by DMHMRSAS contain adequate provisions relating to informed consent to treatment and the appointment of properly authorized substitute decisionmakers.

2.1. To review and comment to DMHMRSAS on the proposed human rights regulations at all stages of the regulatory process.

Indicator was: / /Met / X /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

DRVD continues to review each iteration of the proposed DMHMRSAS human rights regulations. DRVD's most recent comments will be submitted once DMHMRSAS publishes the latest iteration of the regulations for public comment, expected in FY 2001. In April 2000, DRVD's preliminary comments were shared with the Advocacy Committee of the state Mental Health Planning Council.

CASE EXAMPLES AND SYSTEMIC ACTIVITY FOR PRIORITY 3

Example 1. AR, a 48 year old female became a client of the Department for Rights of Virginians with Disabilities (DRVD) on July 16, 1999. AR, who was diagnosed with Depression, had been deemed capable of giving informed consent by her physician upon admission to a state facility. Several weeks later, when AR disagreed with her physician regarding treatment issues and refused medications, the physician decided that AR no longer had the capacity to make informed decisions regarding treatment and proceeded to ask a family member to be her Authorized Representative for substitute decision-making purposes. Over several months, DRVD represented AR at three Local Human Rights Committee (LHRC) meetings and one State Human Rights Committee (SHRC) meeting to advocate for her right to give informed consent for treatment to be restored.

The LHRC and the SHRC upheld the decision that AR was not capable of giving informed consent and that she needed an Authorized Representative. DRVD assisted AR in her efforts to be transferred to another unit within the facility since it was evident that she had come to an impasse with her treatment team regarding this issue. As a result AR was transferred to another unit within a few weeks. DRVD met with AR's new physician and discussed the issues which DRVD had been assisting her with before her transfer to the new ward. The physician then met with AR and discussed treatment issues with her. As a result AR's physician determined that she was capable of giving informed consent and restored her right to make her own treatment decisions. DRVD successfully advocated for AR to have her right to give informed consent for treatment restored in the state facility. AR continues to exercise her right to give informed consent for treatment.

Example 2. This PAIMI case involved a 44 year-old male consumer with a mental health diagnosis residing at a state mental health facility. G.L. had a long history of psychiatric hospitalizations in Virginia and North Carolina. His re-admissions generally occurred when he stopped taking his medication, and he was often non-compliant with medication when he first entered the hospital. GL complainted to DRVD that he was receiving medication over his objection with no court order or Authorized Representative (AR).

The PAIMI staff attorney called the facility director and found that GL had an AR--his mother--and that she had given permission to medicate GL over his objection. The PAIMI staff attorney visited GL at the facility and discussed the medication and AR issues with him

and spoke with his mother by phone on two occasions. She indicated that she did not want to be the AR because she is afraid of her son when he is delusional, but she felt pressured by the hospital to take on this role. She also asked that GL not be told that she was acting as his AR. The staff attorney informed GL's mother that she had already shared this information with GL and that he had a right to know who was serving as his AR. After speaking with the facility director, the facility risk manager, and the facility advocate about the mother's concerns, the staff attorney discussed with the mother, the steps she needed to take to relieve herself of the AR responsibility if that was her choice. The staff attorney also talked to GL's primary nurse about GL's issues and progress during his hospitalization. The AR issue has been resolved and GL accepts the fact that his mother is his AR and that she thus has the authority to give permission for medication administration over his objection. The staff attorney continues to be involved in this case on another issue.

Systemic Activity

1. **Mental Health Human Rights Conference**. DRVD held a Mental Health Human Rights Conference in October 1999. Because all of the planning for this Conference occurred in the FY 1999. This was reported on in the FY 99 PAIMI Annual Report. A contract was awarded to the Mental Health Association of Virginia (MHAV) and the conference was held at the Doubletree Hotel in Charlottesville, Virginia on October 14-15. The keynote speaker was David Anderson, the head of the Governor's Mental Health Commission (formerly the Hammond Commission). Speakers included a variety of individuals from inside and outside of state government, including the Bazelon Center for Mental Health Law, and the National Mental Health Association. Strands in the conference were as follows: (1) The P&A system in Virginia: A Historical Perspective and Future Direction; (2) Proposed Human Rights Regulations; (3) A National Perspective: Mental Health Human Rights Initiatives; (4) The Consumer Movement from a National Perspective; (5) Information from Offices of Consumer Advocacy in Maryland and Virginia; (6) The Civil Commitment Process; (7) The Status of System Reform Initiatives in Virginia; (8) The Rights of Youth with Serious Emotional Disturbance in the Juvenile Justice System; (9) Amnesty International; (10) The Role of Consumers in Treatment and Medical Decision; and (11) Local and State Human Rights Committees and How Concerned Individuals Can Become Members. One hundred and sixty individuals attended the Conference.

   DRVD signed a contract with the Mental Health Association of Virginia (MHAV) in the Spring of 2000 to jointly sponsor, with DRVD, a second mental health human rights conference. In early September, less than 2 months before the planned Conference date, MHAV informed DRVD that due to internal issues, it would be unable to comply with the terms of the contract. The Conference has been postponed until June 2001. DRVD will be reissuing the Request for Proposal to contract with another individual or organization to plan and conduct the conference in collaboration with DRVD.

2. **Human Rights Regulations**. See description under Indicator 2 for Priority 2.

Priority 4 *To provide advocacy and legal representation to residents of DMHMRSAS mental health facilities who have been determined ready for discharge by their treatment team but who remain hospitalized due to a lack of appropriate community resources and supports.*

Indicator 1. To identify failure to discharge trends/patterns through targeted casework

activity at Central State Hospital, Western State Hospital and Northern Virginia Mental Health Institute for the purposes of facilitating systemic change.

1.1. To provide information and referral services and/or technical assistance services to all individuals who contact DRVD regarding discharge issues.

Indicator was: / X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

All callers receive I&R and/or TA services as appropriate.

1.2. To provide case level advocacy services to persons who meet the established case selection criteria of whom at least 20% shall be members of minority populations.

1.3. To provide legal representation services to persons who meet the case selection and litigation selection criteria of whom at least 25% shall be minorities.

Indicator was: /X /Met / /Partially Met/Continuing / /Not Met
If "Not Met" was checked, explain:

Case level advocacy and representation services were provided to individuals whose issues fell with the priority. Forty-one percent of persons served were minorities. Case examples are listed below.

Case Examples and Systemic Work

Example 1. A young woman, diagnosed with bipolar disorder and borderline personality disorder, complicated by mild retardation secondary to perinatal hypoxia, was assessed by her facility treatment team as ready for discharge. She had been hospitalized for four years and had previous hospitalizations. However, her Community Services Board told her parents and treatment team that she was not eligible for any of the supportive services they provided. She was denied case management services and denied services by the assertive community treatment team. Following DRVD's request for records and a meeting to discuss discharge options, the CSB allotted funds for a supported apartment and other community services. Discharge was effected with community supports provided.

Example 2. DH, a 40 year old, Caucasian male, with Mental Illness (MI) and Mental Retardation (MR) became a client of the Department for Rights of Virginians with Disabilities (DRVD) on June 14, 2000. DH resided in the state hospital and had been deemed ready for discharge by his treatment team. He was in need of Medicaid Waiver funding to provide him with a residential placement and the necessary supports to enable him to successfully live in the community.

DRVD contacted DH's hospital social worker to discuss what discharge planning efforts had taken place prior to DRVD's involvement with the case. DH had agreed to an adult foster care setting if one could be found and the funding could be secured. The MR Services Director at DH's Community Services Board (CSB) disagreed that the CL. should be served by the MR Medicaid Waiver program and believed that his level of functioning was higher than previous assessments had determined. The CSB MR Director believed that DH's most recent functional assessment was biased since it was completed by staff at the state hospital.

An independent functional assessment was conducted by another CSB for DH on June 22, 2000 at the state hospital. The results showed that DH's level of functioning met the criteria to be eligible for Medicaid Waiver funding. On June 29, 2000 DRVD contacted the DMHMRSAS Quality Regional Manager, who had been working with DH's CSB MR Services Director on Medicaid Waiver placements, to determine if DH's information had been received regarding his approval for MR Medicaid Waiver funding. The information had not been received. On June 30, 2000 DRVD spoke with the MR Services Director at DH's CSB (after many previous attempts) to discuss DH's case and his right to be placed in the community. The CSB MR Services Director informed DRVD that DH had been approved for MR Waiver funding and that the packet of information would be sent to the state department of mental health on this date.

In July 2000 a Medicaid Waiver provider was located for DH. DH and his hospital treatment team determined that his needs could be met by this provider, therefore special visits between DH and the provider were arranged so that they could get to know one another. In August 2000, trial visits to DH's community placement were started in order to begin his transition back into the community. By September 2000 DH had transitioned exceptionally well and was discharged from the state hospital. DRVD successfully advocated for DH to receive Medicaid Waiver funding to enable him to live in the community. DRVD maintained close contact with DH throughout his transition to the community. DH was discharged from the state hospital on September 30, 2000.

Example 3. A young woman with a long history of schizophrenia was determined to be ready for discharge from the state psychiatric facility where she was resident. After a year of disagreements, the patient's guardian sought DRVD services because she was unsatisfied with any of the options offered by the CSB. The agency has attended multiple meetings directed at identifying an appropriate discharge placement and supports. A placement agreeable to both parties has been identified and discharge is anticipated within the next six to eight weeks.

Systemic Activity

1. **Olmstead Activity.** On February 21, 2000, DRVD advised DMHMRSAS that the Supreme Court's decision in *Olmstead* placed an affirmative obligation on states to devise a comprehensive plan for placement of qualified individuals in integrated community settings, and requested a copy of DMHMRSAS plan for compliance. On February 28, 2000, DMHMRSAS responded with a copy of the Comprehensive State Plan 2000-2006. On March 21, 2000, DRVD attended a presentation by HCFA Office for Civil Rights at DMHMRSAS regarding *Olmstead*. In April 2000, the PAIMI Managing Attorney participated in a meeting with NAMI, the Bazelon Center, ALCU-Virginia Chapter, NAPAS, and NAMI-VA regarding *Olmstead* activities in Virginia. On May 4, 2000, DRVD sponsored a second presentation by HCFA/OCR for invited advocacy and consumer organizations.

   On May 18, 2000, DRVD certified probable cause to believe that patients in DMHMRSAS facilities who were determined "ready for discharge" but remained unnecessarily institutionalized due to lack of appropriate community resources were subject to neglect, and requested that DMHMRSAS provide a list of all such residents. On June 9, 2000, DMHMRSAS denied this request. On July 31, 2000, DRVD served DMHMRSAS with a copy of a draft HCFA/OCR complaint regarding five (5) residents at state mental health facilities as well as a related draft federal court pleading, and

indicated that DRVD would pursue legal remedies unless the two agencies could work collaboratively. Subsequently, the Commissioner advised that he did not have a list of "ready for discharge" patients and on August 24, 2000, DRVD was asked to participate in a focus group regarding the development of the State Comprehensive Plan 2004-2008. A key element of this plan is the development of State Facility Waiting List Data Base to identify all residents of state facilities who are deemed "ready for discharge" and the community services and supports needed. On August 29, 2000, the Director of DRVD and the Commissioner of DMHMRSAS DRVD met to discuss *Olmstead* compliance issues. Of the five (5) patients named in DRVD's draft OCR complaint, three had been discharged into the community at the time of the Director's August 29 meeting with the Commissioner and the remaining two had approved discharged plans. The DRVD Director and DMHMRSAS Commissioner have continued to meet monthly to monitor the status of these patients and discuss other interagency issues.

DRVD will continue to pursue advocacy strategies to identify all individuals in DMHMRSAS facilities who are ready for discharge. Barriers include a lack of funding for community placement and services. CSBs need to work regionally to develop and support programs to meet the needs of specialized populations. The current non-availability of Medicaid waiver funds will present problems for MI/MR persons awaiting discharge to the community.

2. **Mental Health Planning Council.** Olmstead issues were also addressed through the Mental Health Planning Council and as noted under Priority 1 above, a PAIMI advocate serves as Chair of the Advocacy Committee of the Planning council. The Advocacy Committee has worked with DMHMRSAS on development of a database which will identify and track those persons who have been determined ready for discharge and who are still hospitalized. The data elements will provide information which will help to identify barriers to discharge so that the appropriate services and community options can be developed. The first draft of the database instrument has been completed and is in review. Previously, a lack of reliable uniform data has hindered development of comprehensive plans and reduced the credibility of requests for additional funding. Reliable data on the population currently served by the system and those awaiting services will enhance planning and hopefully, service delivery.

   The PAIMI advocate maintained ongoing contact with facility directors and facility staff who work on discharge plans and focused on identifying specific problems and barriers, not just for individual clients, but generally. This information was shared with DMHMRSAS through the advocacy committee of the MHPC and was used in the development of data elements and also in the committees ongoing work with the Department on the development of the comprehensive state mental health plan.

3. Relevant legislation which DRVD reviewed and/or monitored/commented covering such issues as

   - Home and Community-Based Waiver for Mental Retardation Study
   - Mental health pre-discharge planning
   - Notice of group homes for persons with mental illness and/or mental retardation
   - Establishment of MHMRSAS Trust Fund from the sale of vacant buildings held by DMHMRSAS for use to enhance and ensure quality of care and treatment provided to consumers with mental illness, mental retardation, or substance abuse.
   - Zoning of group homes

- Study on employment opportunities for workers with disabilities
- Study on Medicaid "buy-in" option for people with disabilities

SECTION III. INDIVIDUAL PAIMI CLIENTS

Provide the number of individual PAIMI clients for the categories that follow. **Count a client only <u>once</u> during each fiscal year reporting period** (even if the client returned for services many times of if many intervention strategies were provided - they are only counted once). Include individuals carried over from the previous year. Do not include individuals represented as part of a group or a legal class action, and individuals who receive only information or referral services.

A. Number of Individual Clients Served with PAIMI Funds.

It is very important to complete each section of this report. **DO NOT leave any blank spaces**. If no clients were served in any category, list zero. Be sure that the total clients served in each sub-category is consistent. The total number of Persons served (A1 + A2) should be the same number for totals in age, sex, and living arrangements.

Section III. A. NUMBER OF INDIVIDUAL CLIENTS SERVED WITH PAIMI FUNDS (contd.)

1. Number of clients receiving advocacy at start of fiscal year: 40

[This category reflects the number of clients supported with P &A dollars (P&A funding or program income) who had open cases on October 1. Do not report clients who were served with non-federal dollars. Report that activity in Section VIII of this report].

2. Number of new/renewed clients represented during fiscal year: 63

[This is the number of clients who had a case opened during the reporting period (after October 1 and before September 30.) Do not report clients who were served with non-Federal dollars. Report that activity in Section VIII of this report].

Total 103

[Add the numbers from items A.1. and A. 2. This total is the number of cases opened and served with P&A dollars (Federal funding) during the fiscal reporting period. It is an unduplicated count of individuals who received individual case representation].

3. If program income or carryover was used to supplement the P&A allotment for the reporting period, estimate the number of individuals served as a result of carryover program income dollars this fiscal year.

   There was no program income in the PAIMI program. Each year, DRVD carries over a certain amount of its previous year grant award. All available funds are utilized to support advocacy, representation, training and other program activities. Funds are not allocated by client as most of the cost of advocacy services is in the form of staff salaries. It is not possible for us to determine the number of clients served with carry-over vs. current year income.

[Estimate the number of clients served with carryover or program income. This number is needed to demonstrate how program income increases the ability of the P&A program to serve individuals (to further the purpose of the PAIMI Act].

4. The number of individuals who requested individual advocacy **and** who were eligible for services under the PAIMI Act [42 U.S.C. 10801 et seq.] but not 'served' within 30 days of initial contact due to insufficient PAIMI funding or non-priority issues (include individuals who received other services such as information and referral in-lieu): 44

5. Identify populations, advocacy issues and activities (systemic, legislative, educational, training, etc.) that will need to be addressed in the future:

   A. As reported in FY 1999, the principal issue to be addressed in the coming years continues to be the substantial reforms of the mental health/mental retardation service delivery system being addressed through the Anderson Commission, the Governor's Commission on Mental Health/Mental Retardation System Reform and the HJR 240 Legislative Subcommittee. Currently, community mental health programs (community services boards) are only mandated to provide

"emergency" or "crisis" services. There is no statutory or regulatory requirement to provide community-based services to persons being discharged from state facilities and little inducement to return these residents to their communities. An inadequate number of psychiatrists and inadequate medication management programs in local communities have also had negative effects on the success of persons discharged from mental health facilities. Design of a system which provides adequate community based services, to include housing and treatment, for persons already in the community as well as for those being discharged from state mental health facilities is an enormous challenge. The current Administration is committed to improving Virginia's mental health delivery system. DMHMRSAS has also begun to address this issue through a Census Reduction and Community Services Plan and the implementation of performance based contracts with the local community services boards and development of a state comprehensive plan for 2004-2008. DRVD will continue its participation in workgroups, and continue to monitor the work of the Administration and the Legislature to advocate for the inclusion of adequate protections for the rights of persons with mental illness. DRVD will continue to address discharge planning barriers to clients who are currently clinically ready to be released from state hospitals.

B. Protection and advocacy for the rights of persons with mental illness in juvenile justice facilities, jails and prisons remains an unmet need. The PAIMI program has limited expertise in this area and insufficient staff and resources to address this population in the near future.

C. There is a severe lack of community placements and supports for those who are dually diagnosed as MI/MR and those who have brain injury (who do not fit within any other current funding source). An accompanying lack of persons trained in behavioral interventions with this population aggravates the difficulties attendant in maintaining folks in the community or planning and effecting discharges from psychiatric facilities.

D. Attorneys who represent consumers in commitment hearings and recommitments lack substantive knowledge of mental health law and practice and spend little time with the person they are to represent. Those who practice criminal law frequently see a Not Guilty By Reason of Insanity (NGRI) plea as a "win" and do not understand nor explain to their clients that commitment as NGRI may subject the consumer to years of hospitalization – stays that may extend long after symptoms of the mental illness are well-controlled with medication. Legislation is needed to address the rights of individuals who plead NGRI, especially the disparity between the term of forensic commitment versus the maximum potential confinement for the underlying criminal charge. Additional NGRI concerns include the fact that hospitals are facing increased numbers of NGRI patients. Some state facilities feel ill-equipped to handle this population and feel that the solution is to transfer the most "dangerous" of individuals to a facility better equipped in terms of services to forensic clients. However this is not always feasible or in the patients' best interest. Often the choice is to receive inadequate treatment or to be inappropriately transferred out of the home community.

E. There is a general lack of affordable residential options for persons with mental

illness. Adult care residences are the only option offered to many and in some areas, there are no ACRs that will accept persons with mental illness. The auxiliary grant money that makes ACRs an option for some is not available to support other housing options, such as a shared apartment with supports.

F. Mental health services to children and adolescents are hard to obtain. There are few available psychiatrists with expertise in treating this population. Yet, the trend seems to be to diagnose children with mental illness earlier and to treat these illnesses with psychotropic medications. Virginia's Comprehensive Services Act (CSA) was designed to make options other than placement outside the home available but still serves only a fraction of those needing services.

G. There is a major shortage of nurses and other qualified staff. Facilities are using short term contract personnel due to this inability to hire permanent professional employees. This reduces the experience base in the facilities and forces existing staff to work excessive overtime. There is also difficulty in recruiting and keeping aides on the psychiatric units; factories in the community pay better for less stressful work.

B. Number of Case Problems of Individual Clients 148

[This refers to the total number of case problems presented at the time the case was opened. *The number may be higher than the total number of clients served by the P&A because each client may have more than one presenting problem to be addressed].

C. Age of Individual Clients

0- 4	0
5- 20	15
21- 59	84
60 - 64	2
65 and over	2

Total Clients_____

Section III.

C. Age of Individuals Contd.

[Check to ensure that the total number of clients served in each sub-category is consistent. The total number of individuals served in categories A.1 + A. 2 should be equal to the total for C. - *age*].

D. Sex of Individual Clients

Male	69
Female	34

Total 103

[Check to ensure that the total number of clients served in each sub-category is consistent. The total number of individuals served in A.1 + A. 2) should be equal to the total for D. -sex].

E. Ethnic/Racial Background of Individual Clients

The data in this category is self-reported. Please do not question self-reported data. Each client may select one or more categories.

1. Ethnicity:

a. Hispanic or Latino	0
b. Not Hispanic or Latino	102
c. Information not provided	1

2. Race:

a. American Indian or Alaska Native	3
b. Asian	0
c. Black or African American	25
d. Native Hawaiian or Other Pacific Islander	0
e. White	74
Information Not Provided	1

[Clients may select one or more ethnic/racial categories. P&A staff must ask and report this information].

F. Clients' Living Arrangements at Intake

Independent	1
Parental or other Family Home	4
Community Residential Home (e.g.,supervised apartment, semi-independent, halfway house, board & care, small group home 3 or less)	3
Foster Care	0
Nursing Home(includes ICF, SNF, ICF/MR, etc.)	0
Psych wards of general hospitals (public or private) or their emergency rooms	0
Public (State Operated) Institutional Living Arrangement (e.g., hospital treatment center/school or large group home more than 3 beds)	82
Private Institutional Living Arrangement (e.g., hospital or treatment center, school or large group home more than 3 beds)	5
Legal Detention/Jail/Detention Center	6
Prison	2
Homeless	0
Federal Facility (List)	0

Total Client Cases by Living Arrangement 103

[Check to ensure that the total number of clients served in each sub-category is consistent. The total number of individuals served in A.1 + A. 2) should be equal to the total for F. - Living Arrangements at the time of Intake].

SECTION IV. CASE COMPLAINTS/PROBLEM AREAS OF INDIVIDUAL CLIENTS

Major complaints/problem areas presented by PAIMI clients were addressed through the provision direct client services which are listed in the following charts. Enter the number of complaints addressed by the PAIMI program on behalf of clients in the last fiscal year. Since many clients received PAIMI assistance on more than one complaint, the total number of complaints may exceed the served.

NOTE: DRVD cannot complete the "Outcome" column related to complaint areas. This is a new requirement which was not included in the draft revised PAIMI report provided to the P&As last year. We do not track outcomes by case problem area. It is our understanding that the guidance from CMHS (as with ADD) has been that the "outcome" category related to the overall case. Consistent with this guidance, DRVD chooses the most appropriate outcome or outcomes related to the closure of the case, regardless of how many case problem areas are addressed. We do not at the current time have the capacity to track outcomes by case problem area and our database does not support this structure. We will work with our systems engineer and examine our data collection forms to determine whether it is feasible to track this information by CPA and if so, will incorporate in the FY 2001 federal report.

A.1. ALLEGED ABUSE: Number of Complaints/Problem Areas of Alleged Abuse:

Areas of Alleged Abuse	**Outcome**	**# of Complaints From Closed Cases Only**
a. Inappropriate or excessive medication		7
b. Inappropriate or excessive physical restraint, isolation or seclusion		8
c. Involuntary medication		2
d. Involuntary ECT		1
e. Involuntary aversive behavioral therapy		0
f. Involuntary sterilization		0
g. Failure to provide appropriate mental health treatment		6
h. Failure to provide needed or appropriate treatment for other serious medical problems		3
i. Physical assault		2
j. Sexual assault		1
k. Threats of retaliation or verbal abuse by facility staff		0
l. Coercion		0
m. Financial exploitation		0
n. Other. **Please describe on a separate sheet. This number should be less than 1% of the total # of abuse complaints. Make every effort to report within the above categories.		
TOTAL (Sum of a. - n.)		30

A. 2. Complaints Disposition: For closed cases, provide the numbers of abuse complaints or problem areas for each disposition category.

a. # of Complaints/Problems Determined Not to Have Merit on Investigation 15
b. # of Complaints/Problems Withdrawn or Terminated by Client 3
c. # of Complaints/Problem Favorably Resolved in Client's Favor 12
d. # of Complaints/Problem Not Favorably Resolved in Client's Favor 0
e. Total Number of Complaints/Problem Addressed From Closed Cases 30

ABUSE OUTCOME STATEMENT

For each area of alleged abuse, choose one or more outcome statements that either best described or related to the complaint/problem area. Enter the appropriate letter(s) in the "outcome" column in the above table A.1.

A. Persons with disabilities whose environment was changed to increase safety or welfare **1**
B. Positive changes in policy, law or regulation re: abuse in facilities (describe facility where impact was made) **1**
C. Investigations of abuse by the P&A **7**
D. Validated abuse complaints that have favorable resolution as a result of P&A intervention **1**
E. Other indicator of success or outcome _____ **0**

[Items a-d should equal the Total # of Complaints in Table A.1.)

B. ALLEGED NEGLECT.
1. Number of Complaints/Problem Areas of Alleged Neglect: Failure to Provide For Appropriate. . .

Areas of Alleged Neglect	**Outcomes**	**# of Complaints From Closed Cases Only**
a. Admission to residential or inpatient care facility		0
b. Transportation to or from treatment facility		0
c. Mental health diagnostic or other evaluation (does not include treatment)		0
d. Medical (non-mental health related) diagnostic or physical examinations		0
e. Personal care (e.g., personal hygiene, clothing, food, shelter)		1
f. Personal safety (physical plant and environment)		0
g. Personal safety (client-to-client abuse)		4
h. Written treatment plan		0
i. Rehabilitation/vocational programming		0
j. Discharge planning		12
k. Release from institution		4
l. Other. [Please describe on a separate sheet. This should be less than 1% of total neglect complaints. Make every effort to report within the categories identified above.		0

Areas of Alleged Neglect	Outcomes	# of Complaints From Closed Cases Only
TOTAL (Sum of a -l)		21

SECTION IV. Contd.

B. 2. Complaints Disposition: For closed cases, provide the total number of neglect complaints or problem areas for each disposition category.

a. # of Complaints/Problems Determined upon Investigation Not to Have Merit 0
b. # of Complaints/Problems Withdrawn or Terminated by Client 0
c. # of Complaints/Problem Resolved in Client's Favor 20
d. # of Complaints/Problem Not Resolved in Client's Favor 1
e. Total Number of Complaints/Problem Addressed From Closed Cases 21
(Sum of a-d Should Equal the Total # of Complaints in Table B.1.)

NEGLECT OUTCOME STATEMENT

For each area of alleged neglect, choose one or more outcome statements that either best described or related to the complaint/problem. Enter the appropriate letter(s) in the "outcome" column in table - B.1.

A. Investigations of neglect with P&A involvement. **13**
B. Validated incidents of neglect by type. **1**
C. Positive changes in policy, law or regulation regarding neglect in facilities (describe facilities). **0**
D. Persons with disabilities discharged consistent with their treatment plan after P&A involvement. **11**
E. Persons with disabilities who had treatment plan that met selected criteria as a result of P&A involvement **2**
G. Other outcomes as a result of P&A involvement
1. DRVD was successful in having client moved to another facility closer to his home.
2. DRVD was able to resolve discharge planning issue.

C. ALLEGED VIOLATION OF RIGHTS

1. Number of Complaints/Problem Areas on Protection of Rights:

Areas of Alleged Rights Violations	Outcome	# of Complaints from Closed Cases Only
a. Discrimination in housing		0
b. Discrimination in employment		0
c. Denial of financial reimbursements or entitlements (e.g., SSI, SSDI, Insurance)		0
d. Problems with guardianship/conservatorship		0
e. Denial of information about rights protection or legal assistance		0
f. Denial of privacy (e.g., right to congregate, make/receive telephone calls, receive mail)		0
g. Denial of recreational opportunities (e.g., grounds access, television, smoking)		2
h. Denial of visitors		0
I. Denial of access to records/correction of records		0
j. Breach of confidentiality of records (e.g., failure to obtain consent to disclose)		0
k. Failure to obtain informed consent (may overlap with Involuntary treatment)		13
l. Failure to provide education (consistent with IDEA and state requirements)		0
m. Problems with advance directives		0
n. Denial of parental/family rights		0
o. Problems with consumer finance issues		0
p. Problems with immigration		0
q. Problems with criminal justice issues		0
r. Denial of community habilitation services		0
s. Problems with health insurance/managed care		0
t. Other. [Please Describe on a separate piece of paper) This should be less than 1% of total # of violation of rights complaints. Make every effort to report within the above		1

Areas of Alleged Rights Violations	Outcome	# of Complaints from Closed Cases Only
categories.] **Comprehensive Service Act issue**		
TOTAL (Sum of a. - t.)		16

C. 2. Complaints Disposition: For closed cases, provide the number of rights violations complaints or problem areas for each disposition category.

a. # of Complaints/Problems Determined Not to Have Merit on Investigation 5
b. # of Complaints/Problems Withdrawn or Terminated by Client 2
c. # of Complaints/Problem Favorably Resolved in Client's Favor 8
d. # of Complaints/Problem Not Favorably Resolved in Client's Favor 1
e. Total Number of Complaints/Problem Addressed From Closed Cases 16
[Items a-d should equal the Total # of Complaints listed above in Table C.1]

VIOLATIONS OF RIGHTS OUTCOME STATEMENTS

For each of the areas of alleged violation of rights, choose one or more outcome statements that best describes or is related to the complaint/problem area. Enter the appropriate letter(s) in the "outcome" column in the table above.

A. Persons with disabilities served by the P&A who 's 'rights' were restored as a result of P&A Intervention. **6**

B. Persons with disabilities whose personal decision making was maintained or expanded as a result of P&A intervention. **7**

C. Policies or laws changed and other barriers to personal decisions making eliminated as a result of P&A intervention. **7**

D. Other outcomes as a result of P&A involvement **0**

SECTION IV. Contd.

D. INTERVENTION STRATEGIES TO ADDRESS INDIVIDUAL CLIENTS

Complaints/Problems Areas: Enter the number of intervention strategies used to address each client complaint/problem area. A client may have more than one complaint and each complaint may require more than one intervention strategy. The total number of intervention strategies may exceed the total number of clients served. **[Do <u>not</u> report each phone call, letter, meeting, or other action taken on behalf of a client as a separate intervention strategy. Referrals, counseling, and negotiation are considered cumulative processes**]. See Glossary for the definitions of "Intervention Strategies.

<u>NOTE</u>: DRVD cannot complete the "Outcome" column related to complaint areas. This is a new requirement which was not included in the draft revised PAIMI report provided to the P&As last year. We do not track outcomes by intervention strategy. As noted in the earlier section, our understanding of the guidance from CMHS (as with ADD) has been that the "outcome" category related to the overall case. Consistent with this guidance, DRVD chooses the most appropriate outcome or outcomes related to the closure of the case, regardless of intervention strategy. We do not at the current

time have the capacity to track outcomes by case problem area and our database does not support this structure. We will work with our systems engineer and examine our data collection forms to determine whether it is feasible to collect the information in this way and if so, will report this information in the FY 2001 federal report.

OUTCOME STATEMENT

For each of the areas of alleged abuse, neglect, or rights violations, choose one or more outcome statements that best describes or is related to the complaint/problem area. Enter the appropriate letter(s) in the "outcome" column above.

A. Persons with disabilities served by the P&A whose complaint of abuse, neglect, discrimination of their rights was remedied by the P&A. **35**
B. Persons with disabilities who secured access to administrative and judicial processes as a result of P&A intervention. **3**
C. Persons with disabilities who secured information about their rights and strategies to enforce their rights as a result of P&A intervention. **33**
D. Persons with disabilities who took action to advocate on their own behalf as a result of P&A intervention. **12**
E. Allegations of abuse or neglect that were substantiated by P&A **3**
F. Allegations of abuse or neglect that were not substantiated by P&A **17**
G. Other outcomes as a result of P&A involvement_____

Intervention Strategies	Outcome	Number
1. Short Term Assistance:		10
2. Abuse/Neglect Investigations:		6
3. Technical Assistance:		27
4. Administrative Remedies:		16
5. Negotiation/Mediation:		78
6. Legal Remedies:		0
TOTAL # of Invention Strategies		137

[Add items 1. - 6.]

[Complete any of the above outcomes that are appropriate. Refer to the data in Table C. 1. to identify completed outcomes. For example, technical assistance (TA) in self- advocacy should result in the outcome " persons who secured information about their rights and strategies to enforce their rights. . . .

SECTION IV.

E. DEATH INVESTIGATION ACTIVITIES

1. Number of deaths in residential facilities for individuals with mental illness reported overall, throughout the State. 57*

This figure was provided to DRVD by the state Department for Mental Health, Mental Retardation, and Substance Abuse Services for deaths in DMHMRSAS state mental health facilities. Of the 57 deaths, forty-nine (**49)** of the individuals who died were geriatric patients.

If information is not available, check here _____ and explain:

2. Number of deaths in residential facilities for individuals with mental illness investigated by the PAIMI program. 9

Describe the nature of the involvement:

1. A PAIMI Advisory Council member informed DRVD of the death by suicide of a patient at a state hospital. The advocate reviewed facility records, autopsy report and death certificate; met with the facility Risk Manager and conducted interviews with facility residents and sent records to a medical expert for an independent review. Although the investigation found no abuse or neglect, it was determined that the patient had hung himself from exposed electrical conduits. In January and February 2000, the PAIMI advocate conducted a facility survey with the Western State Hospital Risk Manager regarding progress on facility hazard abatement. All electrical conduits in patient living areas had been removed or modified and all bathrooms had been equipped with breakaway shower curtains, showerheads, and shower rods.

2. DRVD was informed of a death by apparent natural causes through a newspaper editorial. The advocate reviewed facility records; conducted interviews with facility staff and family members; reviewed records from other health care providers; sent records to an expert reviewer; and met with a private medical malpractice attorney and the patient's family. The investigation was completed and case closed with no finding of abuse or neglect.

3. DRVD became aware of the death of a patient at a state run psychiatric facility following DMHMRSAS 'release of a statement to the newspaper on June 13, 1999. The decedent suffered fatal brain injury in an attack by another patient on his ward. DRVD located and contacted the next of kin who authorized the release of confidential patient records. DRVD reviewed the decedent's records and interviewed hospital staff. The facility's internal investigation report on the incident was also obtained and reviewed. Efforts to access the records of the assaulting patient were unsuccessful due to pending criminal charges and the refusal of the alleged attacker or his court appointed counsel to authorize access to records. Although several deficiencies in hospital handling of the situation were uncovered, it was impossible to conduct a complete investigation without access to the assailant's records. The family of the deceased patient has retained counsel who is pursuing a potential civil claim.

4. An elderly woman died unexpectedly in April 2000 while a resident of a state hospital. Per policy prior to the new Access Agreement, the facility requested permission from her next of kin to notify DRVD of her death. DRVD contacted the next of kin who authorized access to records. Initial review indicated that the probable cause of death was pulmonary embolism; this, juxtaposed to a recent fall and history of severe peripheral vascular disease circulation leading to bilateral

femoral bypass surgeries, gave reason for further review of medical care. Remaining pertinent medical records have been received and are under review. This investigation is ongoing.

5. DRVD was notified of the death of CR by a phone call from NAMI VA. A PAIMI staff attorney completed the investigation and prepared the draft investigative report pending review and findings from a medical expert. The new PAIMI staff attorney took over the investigation. The expert submitted a report in August 2000 which was inadequate and inconclusive. The case is now two years old and without a comprehensive medical review opinion, DRVD can not draw any valid conclusions regarding abuse or neglect. DRVD has communicated its factual findings and information to a private attorney who is pursuing a potential civil case on behalf of the estate of CR.

4. Case was opened based on Associated Press newspaper coverage of the death of SN at a state mental health facility supporting probable cause of medical neglect. The case was assigned to DRVD contract counsel who conducted a full investigation including interviewing staff, residents, and family members of the decedent, a review of medical records, and reports of internal review by DMHMRSAS. The investigation concluded that the resident died of acute hemorrhagic pancreatitis which was not properly diagnosed or treated, directly resulting in his death. The resident's family has retained private counsel to pursue a wrongful death action. DRVD has shared all investigative information and evidence obtained with the personal representative of the decedent. A public investigative report was issued by DRVD in October 1999.

5. Case #3. DRVD was informed of the death of JS (due to unknown causes) by a consumer advocate in Nothern Virginia in February 1999. The patient died within 24 hours of admission to a state facility. Based upon probable cause, the DRVD staff attorney conducted a full investigation which included a review of patient records, the autopsy report, the death certificate, and internal root cause analysis. DRVD concluded that JS did not receive a timely and adequate physcial examination upon admission, and that the on-call physicain did not perform an in-person examiniation despite evidence that the patient was in distress. JS died of hypertrophic cardiomyography. JS had no identified next of kin, and a public investigative report was published by DRVD in January 2000.

6. A 31 year old man died one week after voluntary admission to a private psychiatric facility. The cause of death was respiratory arrest. His mother contacted DRVD for assistance in filing complaints with the appropriate agencies. DMHMRSAS licensure had already been contacted and conducted a thorough investigation which substantiated the mother's concerns. DRVD assisted in the filing of complaints with the state Department of Health, the U.S. Department of Justice, Civil Rights Division, and Joint Commission on Accreditation of Health Care Organizations. The mother was an exceptional advocate for her son and had contacted and retained private counsel prior to requesting assistance from DRVD. Suit has been filed by private counsel.

DRVD also conducted a death investigation of an individual who died at a local jail. This investigation is not included in the total above which requests information on investigations conducted of deaths of persons who resided in *a residential facility for individuals with mental illness*

A 52 year old woman died within hours of her admission to a local jail in February 2000. Her husband contacted DRVD for help. The autopsy confirmed the spouse's suspicion that an overdose of prescription medication was the cause of death. Records have been obtained and reviewed and facility staff interviewed. There are three additional interviews to be conducted prior to completion of the investigation.

SECTION V. INTERVENTIONS ON BEHALF OF GROUPS OF INDIVIDUALS

A. Summary Information

Type of Invention	Potential # of individuals impacted	Concluded Successfully	Concluded Unsuccessfully	On-going
Group Advocacy - non Litigation	40	3		
Investigation (Other than Death)				
Monitoring Services in Facilities	244			1
Monitoring - Court Ordered	0			
Class Action Litigation	0			
Other	0			
Total	284	3		1

This table captured information on how the P&A program used its Federal funding or program income for non-individual client services. This information was not reflected in previous sections of this report. The activities reported in this table should be linked to the priorities for this fiscal reporting period. The sub-categories listed in the left column of the table (and the numbers for each category) should relate to the narrative section that follows.

Provide at least **one example tha**t reflected the outcome of each sub-category listed in the above. The narrative should briefly describe your PAIMI program activities. Use examples of work that illustrate the impact of P&A program activities. Focus on how these activities made a difference and/or improved the quality of life for your clients. Write your description as if you were telling a story. Include descriptive information on who was involved (the facts about the activity), why the P&A program addressed the issue, how the P&A activities made an impact and, what resulted from this P&A intervention. If program income was used to support any of the above referenced P&A activities, then describe how the program income increased your ability to further the purposes of the PAIMI Act.

1. **Non-litigation Group Advocacy.**

   A. **Grounds Access for Patients.** The DRVD staff attorney negotiated with the state mental health facility to have the door to Homeroom 26 unlocked in building 12. These patients who did not have escorted grounds privileges had been confined to a locked room from 9-3 each day and provided activities in that room. Facility staff claimed the locked door was justified and was needed to protect lower functioning patients from "predators." The facility also argued that there was a "monitor" stationed at the door who could unlock it for a patient to go use the phone, smoke, etc. The PAIMI staff attorney intervened and noted that the "monitor"

could watch those "predator" patients (a total of 3-5), but that the entire group (18-25) should not be restricted based on the behaviors of a few. The door was unlocked.

B. **Therapy Group Participants.** At a state mental health facility, the sexual abuse therapy groups contained both abusers and those who had been victims of abuse, male and female. Two patients complained and said they felt uncomfortable facing abusers in group therapy. The facility stated that they organized their therapy groups in this way because abuse individuals often become abusers, and they needed to treat both problems. DRVD intervened, and the facility decided to offer two separate groups: one for patients who had been abused only; and one for patients who had been an abuser even if he or she had also been abused. Approximately 15 persons were affected.

C. **New Sexual Abuse Activity Policy**. The PAIMI staff attorney assisted Eastern State Hospital with developing a sexual activity policy. Three patients complained to DRVD that sexual behavior was treated differently on different wards and among different people. The hospital developed a sexual activity policy on which they requested the PAIMI staff attorney's input. The hospital now has a consistent, uniform policy that applies throughout the facility that addresses all levels of sexual activity, from slight touching to sexual abuse.

2. **Investigation (other than death).** DRVD investigated an incident at a state facility in which a patient hurled himself headfirst into a plexiglass window, resulting in the resident being paralyzed from the neck down. DRVD became aware of the incident as result of a newspaper article. The agency conducted an investigation which included interviews with all staff present at the time and review of the unit's videotape of the incident. The PAIMI advocate also reviewed the draft of the internal investigation report. The DRVD investigation determined that although staff did not comply with established hospital policy in several areas, those commissions were not directly responsible for the incident. The actions taken by the resident were not reasonably foreseeable or preventable. The hospital took prompt disciplinary action against staff who failed to follow hospital policy.

3. **Monitoring Services in Facilities**. As reported above, under Priority 1, the PAIMI team conducted a systemic review of the use of seclusion and restraint at Western State Hospital. The staff reviewed seclusion and restraint data and conducted a site visit to the facility in mid-April. With the assistance of WSH staff, all residents who were secluded or restrained during the previous quarter (January to March 2000) were identified, and DRVD interviewed all who were still present at the facility. Relevant records were reviewed and questionnaires for each incidence of seclusion/restraint were completed. The PAIMI staff compiled the information in a draft report that examines the data in light of written policies regarding seclusion and restraint, and includes a three year trend analysis of seclusion and restraint use and a policy analysis of HCFA and JCAHO regulations. The report is undergoing final review of the policy analysis in light of the Children's Health Act of 2000 enacted on October 17, 2000, which establishes nationwide minimal standards for use of seclusion and restraint. The completed report will be shared with the Commissioner of DMHMRSAS, the facility director, and others as appropriate.

SECTION VI. NON CLIENT DIRECTED ADVOCACY ACTIVITIES

A. Individual Information and Referral (I & R) Services: Provide total number of I &R services. Refer to the Glossary for the definition of "Information and Referral."

Total Number___797_____

Note: This number is substantially lower than the number reported in previous years. This is because for the first time, DRVD is able to (as required by federal funding agencies) differentiate I&R services by program. The numbers provided in previous years related to I&R provided under all of the agency's six programs.

B. Education, Public Awareness Activities And/or Events.

[List public awareness activities or events and the number of individuals who received the information. Refer to the Glossary.

1. Number of Education/Training Activities Undertaken 15

Topic	Date	Audience	Number in Attendance
Treatment Rights/Informed Consent	10/12/99	Virginia Mental Health and the Law, Health Ed	75
The Virginia P&A	10/14/99	Mental Health and Human Rights Conference	160
Human Rights	10/27/99	LHRC at Northern Va. Mental Health Institute	12
Medical Rights	11/5/99	Central State Hospital, LHRC	10
DRVD Services	11/16/99	HJR Committee on Future Delivery of Mental Health and Mental Retardation Services	10
Patient Rights and DRVD Services	11/19/99	Northern Va. Mental Health Institute	27
Court Ordered Treatment	1/13/00	Northern Va. Mental Health Institute	8
Who is DRVD and What is Abuse and Neglect?	2/29/00	Southwest Virginia LEAP Program	30
Introduction to DRVD and PAIMI	3/20/00	Gateway Farms	25
Introduction to DRVD and PAIMI	4/10/00	Virginia House	25
Access Agreement Training	6/13/00	DMHMRSAS/DRVD Staff	110
Access Agreement Training	6/27/00	DMHMRSAS/DRVD Staff	120
Discharge Planning and Your Rights	7/26/00	Western State Hospital	17
DRVD Overview	8/2/00	Psychiatric Resources, Inc.	83
Seclusion/Restraint and Treatment Planning	8/15/00	Western State Hospital	11

[Total number of training programs sponsored by the P&A or the number of events sponsored by another organization where P&A staff were trainers. The training must have provided specific information to participants regarding their rights. If the P&A only provided general program information report the number of individuals trained in B. 2.]

2. Total number of persons trained (approximate) 723

[This number should include only those individuals who attended a training program].

3. Information Dissemination Activities	Outcome	# of Items
a. radio/TV appearances	_____	3

b. newspaper articles (attach select articles)	_____	23
c. PSAs/videos/films/etc. aired	_____	0
d. reports disseminated	_____	162
e. publications disseminated	_____	2,880
f. Information about P&A disseminated (include general training /outreach or presentations not included in training activities)	_____	4,595
g. Number of hits on Website		Unknown

h. Describe other media activities: At the beginning of the fiscal year (10/1– 24/99), DRVD was concluding an outdoor advertising campaign in designated counties in Southwest Virginia designed to increase knowledge and awareness of DRVD in rural areas of the state.

OUTCOME STATEMENT

For each area of non client advocacy activity, choose one or more outcome statements that either best described or related to the complaint/problem. Enter the appropriate letter(s) in the "outcome" column above.

A. Persons who received information about the P&A and its services

4,595

B. Persons with disabilities (or their family members) who received education or training about their rights, enabling them to be more effective self advocates

481

C. Other outcomes as a result of P&A involvement _____

[Data reported in **Section VI** should assist in developing the above outcome statements.

SECTION VII. OTHER SERVICES AND ACTIVITIES

A. List groups (e.g., State Departments of Mental Health, other advocacy organizations, organized groups of recipients/former recipients of mental health services or family members of such individuals) with whom PAIMI worked cooperatively on activities:

1. Department of Mental Health, Mental Retardation, and Substance Abuse Services
2. Mental Health Association of Virginia
3. Mental Health Planning Council
4. National Alliance for the Mentally Ill-Halifax Chapter
5. Advisory Council for Mental Health Services for Persons who are Deaf, Hard of Hearing, and Deaf-Blind
6. Virginia Coalition on Juvenile Justice
7. Department of Social Services Adult Care Residences Advisory Committee
8. The Anderson Commission on Reforming the Mental Health System
9. HJR 225 Committee n Future Delivery of Funded MH and MR Services
10. HJR 225 Medicaid Workgroup
11. International Association of Psychosocial Rehabilitation Services, Virginia Chapter
12. Virginia Public Guardian and Conservator Advisory Board
13. Virginia Guardianship Association
14. Local Human Rights Committees
15. The Disability Commission
16. Coalition for Students with Disabilities
17. Virginia Board for People with Disabilities

18. State Special Education Advisory Committee
19. The Autism Program of Virginia

B. Describe outreach programs to increase the numbers of minority clients and educate minority constituencies about the PAIMI Program .

The public awareness activities to all populations including minorities and underserved populations are listed in the attachment to this report. Last year, DRVD translated all of its publications into Spanish. The effect of this effort is not known. No specific minority outreach activities other than those listed under public awareness were undertaken with the exception of ongoing monitoring of the minority caseload to ensure that minority populations were proportionally represented in the caseload. DRVD's established targets of 20-25% were met with minority representation of PAIMI clients ranged from 21% to 41% percent of those served under the agency's FY 2000 priorities**.** According to the 1998 Census, the percentage of minorities in Virginia's population is 27.7%.

With respect to its Advisory Council, DRVD continued to work with its Advisory Council and staff to increase the number of members on Council and ensure diversity. Efforts this year to increase the number of members on Council have paid off and as of September 30, there were 14 members. Three of those members are minorities. However, in addition to ethnic/racial diversity, there was also an effort to improve representation from rural areas of the state and Council now has an increased number of members from the Southwest areas of Virginia. Recruitment of Council members has halted for now as the agency and Council do not wish to be in a position once again of losing all of its members simultaneously due to like termination dates. Some recruitment to further increase the membership of the Council will take place in the next fiscal year.

C. Did your activities result in an increase of minorities in the following categories?

staff	yes____ or	no_X___
advisory council	yes_X__or	no____
governing board	yes____ or	no____ N/A
clients.	yes__X_or	no____

D. PAIMI Program Implementation Problems:

1. External Impediments:

Describe any hindrances encountered in implementing legally mandated PAIMI activities (e.g., denial of access to clients, facilities or records; lack of cooperation or resistance from service provider agencies):

Virginia has no statutes which provides a right to community mental health treatment. The only mandated services are emergency services (pre-screening for commitment) and collaboration with state hospitals on discharge planning. Therefore, there is no state statutory support to force development of community placements or the services necessary to support persons with serious mental illness in those placements.

Delay in promulgation by the Board of DMHMRSAS of the human rights regulations led to an inability to complete objectives relating specifically to these regulations. These objectives have been carried forward to the FY 2001 fiscal year.

2. Internal Impediments: Describe any problems experienced in attempting to implement activities identified as objectives or priorities (e.g., lack of staff time or funds; lack of necessary expertise):

There was a vacancy in the PAIMI staff attorney position for a portion of the year resulting in a delay in accomplishing some planned activities. The ability to procure competent medical experts for records review has caused delays in completing some investigative activities.

E. Most Important Accomplishments: Please identify what you feel were the PAIMI program's most important accomplishments in this fiscal year:

1. Passage of DRVD's legislative package has resulted in (1) increased and improved state statutory access to facilities, clients and records; (2) notification of all critical incidents and deaths in state operated mental health and mental retardation facilities; and (3) confidentiality of DRVD's client and investigative records.

2. The newly adopted Memorandum of Understanding with DMHMRSAS will increase access to DMHMRSAS facilities, residents, records, and staff and clarifies procedures to be followed between DRVD and DMHMRSAS. The MOU provides for detailed and timely reporting of deaths and serious incidents and which will significantly improve DRVD's ability to monitor abuse and neglect in facilities, to investigate serious incidents in a timely manner and to provide more effective advocacy and legal services to residents.

3. DRVD completed its first on-site systemic review of seclusion and restraint practices in a state mental health facility. This activity was described earlier in the report under Priority 1 and in the section on Monitoring if facilities.

4. Since May 2000, as a result of the new legislation discussed in # 1 above and revisions to the Memorandum of Understanding reported in # 2 above, the DRVD director has reviewed every 48 hour report provided by the facility directors and every 15 day follow-up report provided by the DMHMRSAS Commissioner. DRVD has developed a comprehensive database to log in all reports and to track incidents in a variety of different ways (including, but not limited to tracking by facility, by ward, by time of day/shift, by type of injury, etc.) The DRVD Program Operations Coordinator provides summary monthly reports to the DRVD Director as part of the agency's efforts to track and analyze trends in the aggregate and to determine actions which should be taken to remediate ongoing systemic problems. This is accomplished in part through monthly meetings between the DRVD Director and the DMHMRSAS Commissioner. When the Director determines probable cause to suspect abuse or neglect, or if probable cause is unclear, staff are assigned intervention activities from the level of preliminary inquiry to full investigation, depending upon facts of the incident. Receipt of critical incident information has enabled the agency to become more proactive in addressing both individual and systemic problems in the DMHMRSAS system.

5. DRVD completed a number of abuse, neglect, and death investigations, some of which were initiated as a result of critical incident reports received from facilities. These efforts have resulted in improved safety and protections for consumers residing in the relevant facilities.

6. DRVD materials are now being included in informational and training materials provided by Eastern and Central State Hospitals to their patients.

7. DRVD continues to be routinely asked to participate in critical task forces and workgroups

studying the improvement of the MH service delivery system in Virginia.

F. Technical Assistance Recommendations: List Recommendations for future PAIMI Program Federal Technical Assistance Activities.

None at this time.